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BULLETIN of the MENNINGER CLINIC

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BULLETIN of the
MENNINGER CLINIC

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FOREWORD

By KARL MENNINGER, M.D.

In April 1945 a Commission of five American psychiatrists—Dr. Leo Bartemeier, Dr. John Romano, Dr. Lawrence Kubie, Dr. John Whitehorn and the writer—were appointed by Brig. Gen. William C. Menninger, acting under the direction of Surgeon General Kirk, to respond to an invitation from General Paul Hawley, surgeon-in-chief of the Army Medical forces in the European Theater to make a study of certain psychiatric problems in the Theater. Upon completion of a tour of approximately 3,000 miles through France, Germany, Austria, Czechoslovakia, Luxembourg and Belgium, the Commission was sent to England where for a period of several weeks its members were guests of the British War Department. We were given an enviable opportunity to study psychiatric techniques and programs as developed by the Medical Corps of the Army, and Navy and the Air Forces. An official report of our observations was made to the Surgeon General upon our return to this country and has since then been released for medical publication elsewhere.

All the members of the Commission "fell in love" with England and its people. One of the things which impressed us most was the skillful use of the principle of group psychology and group dependency in therapeutic programs of various types. It seemed to the writer somewhat paradoxical that the British psychiatrists so generally give the credit for the original stimulus and the development of the basic principles of their work to American scientists but have carried the application of these principles much further than is common in American psychiatric practice. I make full allowance for exceptional instances of group therapy programs in this country; the fact remains that it is not as yet the preoccupation or method of preference in the leading psychiatric hospitals of America, whereas it actually is in England.

Before leaving England I asked Dr. (then Lieut. Col.) G. Ronald Hargreaves, one of the close associates and assistants of Brig. Gen. J. R. Rees who is so well known to us all, to obtain for me, if possible, a series of manuscripts from some of the men in the Psychiatric Division of the Royal Army Medical Corps. He kindly consented and the following papers represent essentially a symposium on the subject of group therapy and group psychotherapy, as used in England. These papers center about the so-called Northfield Experiment. This refers to the utilization of the civil mental hospital building belonging to the city of Birmingham by the Army Medical Corps for the treatment of approximately 800 soldiers with battle neuroses of various types for treatment by group therapies primarily. The Commission mentioned above had the great pleasure of spending several days at Northfield and seeing this work.

Unfortunately it was impossible to include a manuscript describing the use of psycho-drama, the publication of the hospital magazine and a number of other projects which form a part of the Northfield program and all of which were demonstrated to us in a very convincing way.

The Editors of this *Bulletin* are grateful to our British Colleagues for their courtesy in preparing for us these clear and stimulating reports of their work and we are proud to submit them to our readers.

THE HOSPITAL AS A THERAPEUTIC INSTITUTION

By Lt. Col. T. F. MAIN, R.A.M.C.

By tradition a hospital is a place wherein sick people may receive shelter from the stormy blasts of life, the care and attention of nursing and medical auxiliaries, and the individual attention of a skilled doctor. The concept of a hospital as a refuge too often means, however, that patients are robbed of their status as responsible human beings. Too often they are called "good" or "bad" only according to the degree of their passivity in the face of the hospital demand for their obedience, dependency and gratitude. The fine traditional mixture of charity and discipline they receive is a practised technique for removing their initiative as adult beings, and making them "patients." They are less trouble thus to the staff. Hospitals which follow this orthodoxy are usually designed for the individual treatment of the individual patient by an individual doctor, not in a real social setting, but in a state of retirement from society. So, isolated and dominated, the patient tends to remain gripped by the hospital machine even in the games or prescribed occupations which occupy his time between treatments.

Within such a setting, health and stability are too often bought at the excessive price of desocialisation. Sooner or later the patient, alone and unsupported, must face the difficult task of returning to the society in which he became unstable, and there regain social integration, and a daily sense of values and purpose. This task is no light one for a desocialized man, however healthy he may have become.

The design of a hospital as a social retreat also ignores positive therapeutic forces—the social support, and emotional opportunities which are granted in spontaneously structured communities. It is true that radical individual treatment can free the inner drives of the patient, and make him capable of full and stable social life, but it fails to give him an assured technique for full social participation—he can only learn this from the impact of society itself. Treatment of the neurotic patient, who suffers from a disturbance of social relationships, cannot therefore be regarded as satisfactory unless it is undertaken within a framework of social reality which can provide him with opportunities for attaining fuller social insight and for expressing and modifying his emotional drives according to the demands of real life. In any case the fact must be faced that radical individual psychotherapy is not a practicable proposition for the huge numbers of patients confronting the psychiatric world today. It is doubtful whether the hospital can usefully remain a building within which individual treatment is practised. Perhaps it must become a therapeutic institution.

A Therapeutic Community

The Northfield Experiment is an attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life and the eventual aim of the resocialization of the neurotic individual for life in ordinary society. Ideally, it has been conceived as a therapeutic setting with a spontaneous and emotionally structured (rather than medically dictated) organization in which all staff and patients engage. Any attempt to permit or create such a setting demands tolerance, a willingness to profit by error, and a refusal to jump to conclusions; but certain matters appear to be plain. The daily life of the community must be related to real tasks, truly relevant to the needs and aspirations of the small society of the hospital, and the larger society in which it is set; there must be no barriers between the hospital and the rest of society; full opportunity must be available for identifying and analyzing the interpersonal barriers which stand in the way of participation in a full community life.

These are not small requirements and they have demanded a review of our attitudes as psychiatrists towards our own status and responsibilities. The anarchical rights of the doctor in the traditional hospital society have to be exchanged for the more sincere role of member in a real community, responsible not only to himself and his superiors, but to the community as a whole, privileged and restricted only insofar as the community allows or demands. He no longer owns "his" patients. They are given up to the community which is to treat them, and which owns them and him. Patients are no longer his captive children, obedient in nursery-like activities, but have sincere adult roles to play, and are free to reach for responsibilities and opinions concerning the community of which they are a part. They, as well as he, must be free to discuss a rationale of daily hospital life, to identify and analyze the problems, formulate the conditions and forge the enthusiasms of group life. The patients must be free to plan and organize activities of actual hospital procedure, and thus face together problems of immediate social reality. Failures of organization, internal problems of apathy, insecurity, and hostility, as well as ordinary practical difficulties are matters for solution by the patients who own the community and create the problems.

The Psychiatrist's Role

Sometimes because he is an ordinary community member, often because of his special knowledge, the psychiatrist's opinion is sought when difficulties arise. He may attempt resolution of the interpersonal tensions creating the difficulty, by group therapy within a functional or a reflective

group, or may only identify the emotional difficulties involved and leave the solution to the patients. But he does not seek *ex cathedra* status. Indeed he must refuse any platform offered to him, and abrogate his usual right to pass judgment on inter-group claims or problems. The psychiatrist has to tolerate disorder and tension up to the point when it is plain that the community itself must tackle these as problems of group life. In the case of individual behaviour (for example, in men with depression) he may have to wait for a social regression to be worked through and for spontaneous reparative drives to make their appearance, or for the patient to ask for insight into his disturbance or behaviour.

The psychiatrist is ready to re-define a practical problem in terms of attitude or relationships, to reorientate another, illumine a third, and in a fourth to act as a catalyst for social response and awareness. His role as a technician among, rather than a superintendent of, his patients certainly does not mean that he can remain inactive. He should be a sincere commentator and participant in many of the social fields that wax and wane with the varying needs of the fluid population of the hospital, and be prepared to create conditions for the exercise of growing drives and interests or to open channels of communication between certain social groupings. He should be active in providing opportunities for therapeutic intercourse between patients and in modifying the practical barriers of time and geography standing in the way of this. His daily work is to study and facilitate the growth of the social pull and push which allows the isolate to expand in social integration to the therapeutic end of rich social and industrial life relating to the real community in which the hospital is set.

It must be pointed out that the medical man, educated to play a grandiose role among the sick, finds it difficult to renounce his power and shoulder social responsibilities in a hospital and to grant sincerely to his patients independence and adulthood. But it is no easier for the rest of the staff. It is difficult to live in a field undergoing internal stress without wanting to trade upon authority and crush the spontaneity which gives rise to the stress, to demand dependence and to impose law and order from above. Such measures however, do not solve the problem of neurosis in social life, but are a means of evading the issue.

Relations of the Staff

The members of the staff, too, have their problems, their fear, so to say, of the social id, and they have their own emotional needs. Group discussions, (as described in the following papers) held about specific problems, among those who are involved by them, and the exposure of the individual to the social suction and pressure in group meetings of patients and staff discussing matters relating to their daily work, are necessary to prevent the growth of

the barriers which exist between patients and staff in most hospitals. The nursing staff, the kitchen and administrative staffs, the social therapy staff, the psychiatrists, and patients all have sectional and inter-related problems in immediate practical fields and involving interpersonal and inter-group tensions. The granting of social significance and effect to the daily lives of the staff and their integration with the whole hospital community and its purpose, general and in details, is helped by routine meetings, social occasions and by participation in group therapeutic sessions. Apart from the resultant increase in sincerity and social health gained by the extension of the social boundaries of the staffs within the hospital, the effect on "atmosphere" is very important. And only thus can the whole community engage continuously upon its aim of adapting to the needs and problems of its participants.

Individual Needs

Attention to the hospital as a therapeutic community does not, of course, preclude attention to the individual problems of its members. Rather, with the recognition of the legitimate aspirations of others, an increasing provision is freely made by the community for individual limitations and needs. One group of patients, which called themselves "The Co-ordination Group" set up office and prepared to cater on demand to needs in real life which were not provided otherwise by the hospital; they specialized in unusual requests, or in seeking out jobs to suit a patient and in seeking patients to do certain jobs.

Again, the psychiatrist will give individual attention to those whose problems are not being satisfactorily solved within the various therapeutic social fields created in the hospital. The man whose social capacity is too low to allow him participation in a group activity even of "low tension" is free to choose solitary activities; and where his desire is to avoid society and activity, he will be given a single room and permitted to do nothing. For despite the basic conviction that it is no part of the function of a hospital to compel a compulsory retreat from society in exchange for treatment for all those who enter its doors, there are many patients whose best immediate relationship with society is isolation, dependency or personal regression.

Northfield provides facilities to meet these occasions; men mourning the loss of their comrades in battle are given full facilities to carry out this social task; a darkened ward and continuous narcosis is available for those who express themselves by symbolic illness as being in need of a period of infantile behaviour; the man with problems of aggression may be granted a job involving satisfactions for his aggression; and the cynical may receive the support of the personal transference situation until he is able to accept life in a small group of chosen friends. When acute needs have been

satisfied, however, these patients are faced with a wide range of social and industrial opportunities, and are free to move at their own choice and at their own speed within the social fields which best suit them. As every social field is connected by emotional channels with others, the patient thus embarks upon life in a real society which can continue up to a limit, to allow him an expansion of his social relationships. This limit is not set by hospital boundaries, for he may work and form relationships within the wider geographic boundaries set by modern forms of travel.

The Aim

The socialization of neurotic drives, their modification by social demands within a real setting, the ego-strengthening, the increased capacity, sincere and easy social relationships, and the socialization of super-ego demands, provide the individual with a capacity and a technique for stable life in a real role in the real world. The common remark made when a patient is asked on leaving why he is better, is a vague "I don't know why. I found something that suited me. Then I met some nice people. I think that helped." The psychiatrist is rarely mentioned as a therapeutic agent, and where he is highly praised, this is regarded as a failure of therapy. For with increasing social and industrial vectors from the larger society outside the hospital there should be no regrets on leaving; rather an increased zest for life and confidence that the problems it presents can be met and faced without inefficiency or unhappiness.

THE NORTHFIELD EXPERIMENT

By Major H. BRIDGER, Royal Artillery

For the past eight months an attempt has been made to examine how far a continuously changing population of patients and staff could develop its own form of community within the framework of a Military Psychiatric Hospital of 800 beds. It would be impossible in a short article to describe or trace the everchanging scene in detail; on the other hand it would be misleading to discuss one facet of the experiment unless considered within the context of the whole. That aspect of neurosis which is social cannot be isolated from the rest, and certainly cannot be treated solely by a Social Therapy Staff. The "departmental" approach would be as unreal as the treatment of an individual without relation to the societies in which he has lived, is living and will live. Nevertheless in the same way as an administrative staff would serve a community by helping it to function from within and without, so a social therapy staff can play its part in providing opportunities and channels for the development of the community's needs.

Program of Admission

The large majority of men coming into the Northfield Hospital say "I am browned off with everybody and everything," "I am fed up with the Army," "I seem to have lost confidence in myself" or "I hate being pitied" and so on. Let us trace the progress of such a man at the present time. He enters the Admission Ward in the company of a few others and they are met by the nurse and a group of patients whose selected activity it is to act as receptionists and guides in the fullest sense. After the first initial allotting of beds, etc., they are joined by the psychiatrist attached to the Admission Ward. They are each handed a program of their first three days' stay (which entails remaining in this ward), and copy of a magazine produced by the patients called "Introducing you to Northfield." They are asked to read it, discuss and ask any questions they like. The receptionist group deals almost entirely with this, and then splits up to take small numbers of newcomers on a tour of the Hospital, so that the contents of the magazine become a living organism.

They visit the Hospital Club which is run entirely by patients who have selected this as their "activity," they see patients working on the newspaper in their own offices, the band practising for dances and socials, men painting scenery and arranging lights for stage shows, gardens and gardeners, a tennis court in use, the sports facilities, building construction and the Selected Activities yard, where painting, sculpture, handicrafts of all kinds, carpentry, radio construction etc., are all taking place. They see

and enter the ever-open doors of contact officers, welfare workers and so on who are there to help them at any time.

More important still, they see each as a living part of the total pattern and hear what their guides and others have to say about it, spontaneously and in answer to their questions. They hear from the patients that this is part of treatment. They see and hear, for instance, that in the Selected Activities Yard, while each patient is making something for his wife, child or for himself that there is an overall project by which individuals and small groups are providing toys, accessories and fixtures for Child Guidance Clinics and Nursery Schools. They learn that from these activity huts one can 'graduate' to become a member of small groups, each of which has its own circuit of nursery schools to maintain, by mending toys and re-decorating the playrooms (incidentally helping the nurses to bath the babies!).

"But," one or more men will say, "I am not interested in any of this; I am interested in engineering, farming, poultry-keeping, plumbing..." as the case may be. His guide tells him that when he meets his psychiatrist and the Activities Officer he can arrange to conduct his activity at the Austin Motor Company, the Avoncroft Agricultural College and so on, where special facilities are available for them to take part in the life of these communities. Space does not permit further description, but sufficient has been said to show that the man returns to the Admission Ward, despite all other considerations, with a sense of security in his surroundings. This is now helped further by short individual interviews with the senior psychiatrist and then by meeting his own psychiatrist for his initial interview. The activity is selected between them and should it need special arrangement, the patient is interviewed by the Social Therapy Officer concerned, who immediately, in the fullest sense, makes the man a partner in achieving his particular objective. Many men use the activity selected as a test for the psychiatrist and social therapist, or they may use it to test themselves in a real or fantasy role. Particularly is this true of the returned P.O.W. who wishes to have a "farm," and "cottage in the country" or "help to look after horses" etc.

Selection of Activities

It is interesting to note at this point that, whereas eight months ago the new patient would say that he did not want to do anything while in the hospital, and the "older" patient would describe the limited range of activities as jobs to "occupy his mind" or "occupy the time between interviews", each now accepts the activity, *selected by himself* in conference with his psychiatrist, as a recognized part of his treatment. The term "occupational therapy" had contributed to this older conception and is no longer used here; the main factor however, was the limited scope allowed by

orthodox occupational work. The free extensive range and principle of joint selection gives the man every opportunity to satisfy needs or urges. The soldier not infrequently says "I have always wanted to try my hand at . . . but I don't suppose you can do anything about that":

That he is a real partner in achieving the opportunity is a vital matter. This does not mean that all new patients immediately settle down to following their activities with enthusiasm and keenness, or that they will even do so regularly after a few days. The fact that he wanders off for walks on his own or with a friend is information for the psychiatrist, the nurse, the social therapy staff and the men with whom he is working; each deals with the situation within their own overlapping fields. The patient is not 'checked' in the military sense; the social and therapeutic forces at work can safely be left to cope with the problem in a shorter or longer time—he will find his place and activity in a little while, even if he changes the latter two, three or more times.

Recreation

For the rest of his stay in the Admission Ward the man spends his time being "re-kitted," completing questionnaires and psychological tests. In between times and in the evenings he revisits one or more of the places he has already found attractive—the N. A. A. F. I. (Canteen) where he can obtain refreshments and buy any necessary small items he requires, the Club where table-tennis, darts, billards, etc., are always in progress and where in another room he may be drawn into playing in a Whist Drive (bridge tournament) or the gymnasium where a play, variety show, dance or film is taking place. The notice-board in his ward always tells him what is "on"; his host-patient may however bring some of this to his notice or may invite him to join a party going to a dance, theatre or social run by members of local firms, clubs or societies, where he can meet men and women who are having fun, and not just giving him a "good time". In some cases these are the first steps in an England which he may have left three, four or five years ago. The decision is at all times left to him; the opportunities are there and are offered with an encouragement to accept, but his wishes are respected and understood by his fellows.

Introduction to the Treatment Ward

On the afternoon of the third day he is introduced to his Treatment Ward, which is in charge of his psychiatrist and nurse. The ward-workers group (whose selected activity is to look after all domestic affairs in the ward) will 'put him wise' to everything going on. The ward committee members are soon giving and receiving information and their section of the notice

board becomes a focal point. He realises that he will be a member of the ward for the rest of his stay in hospital, and he can now embark on a secure but flexible program, involving not only the life in his ward and his selected activity, but also the social opportunities inside and outside the hospital.

Every day his psychiatrist sees him during the morning round, each week the Commanding Officer of the Hospital makes his inspection and is ready to hear requests and complaints. In addition, the ward holds its own weekly meeting which is attended by the psychiatrist and nurse. The men elect their own chairman who, together with two other elected representatives, attend a full meeting of Ward Committees each Friday. These meetings, on "constituency" and "House of Commons" levels, are extremely useful conductors by means of which domestic and hospital tensions can be transmitted and resolved. Matters affecting the ward are dealt with by the "constituency"; matters bearing on hospital affairs are referred to the "House of Commons". The latter meeting is attended by the Commanding Officer and the senior officer of the Social Therapy Staff, who act as links, should it become necessary, with all hospital departments, any member of which has a standing invitation to attend.

Self-Government

Despite the continual ingress and egress of patients, it is possible, through the growing volume of committee meeting minutes, to trace the trend of a society developing in almost direct proportion to a growing sense of achievement and responsibility. The history and analysis of these meetings would need more than an article for themselves. At the beginning it was a collection of individuals, most of whom were self-appointed ward representatives, airing personal grievances and grumbles. Now it is a constitutional body quite conscious of its value and responsible to the community, considering at this moment plans for a total hospital project related to building an extension to the Crippled Children's Hospital in Birmingham. Its sub-committees deal with dances, socials, the Hospital Club, sports and competitions of all kinds; its meetings are attended by a representative of the newspaper group and reported weekly. The human day-to-day problems of the community are reflected in the discussions and cover every type of problem and every hospital group whether patients or staff.

Its work is not bound by the confines of the hospital. The links between the Northfield community and the city (Birmingham) community are becoming more numerous and more clearly defined. The growing contacts opened up by Selected Activities, sports and parties have brought large

industrial concerns well within the community consciousness, with the result that its psychological as well as geographical field has widened to an extent which tests both Ward and Committee meetings to the full.

The Social Background

It is in relation to this background, the frame of reference set up by the social life of the ward and hospital community, that each psychiatrist has the opportunity of treating his patients, individually and in groups. This frame of reference changes imperceptibly but surely as time goes on, but it has a value which has taught us much. It is more than interesting for a psychiatrist to see how the cohesive and disruptive forces react on the member of his ward in relation to domestic and hospital matters. He can observe behavior which will be of the greatest value in treatment.

So far little has been said of other functional groups within the hospital, but they each have their role to play, not only in maintaining the hospital services and administration but in a contribution to the total community. The women's services in particular take a full and essential share in the social life of the hospital. It may well be said that the Social Therapy staff of a hospital is the whole staff together with the whole of the neighboring population. One can be tempted to add that unless this is so, treatment is limited and may even be sterile. The treatment (one may call it an education in sincerity and tolerance if one wishes) which the patients have given to all related groups must also be an important consideration.

Although it is not possible here to trace in detail either the phenotypical picture of development or the process of 'Lewinfiltration'* (our term for describing the dynamics of the growth of a community pattern), some conception of its progress can be educed by considering first the field existing just prior to the beginning of the experiment and second, the initial rearrangements of bounds.

Without describing the previous social structure of the hospital, it will be sufficient for the purpose to say that entertainment, recreation, education and 'occupational therapy' were extra-responsibilities for three different psychiatrists. 'Rehabilitation' in the hands of a military staff, which dealt only with patients in the last two or three weeks of their stay in the hospital consisted mainly of para-military training.

Development of the Community

By mutual arrangement with the unit concerned, the function of the 'Training Wing' was delegated to the Convalescent Depot through which most patients passed who were returning to the Army. The new Social Therapy Staff then undertook responsibility for all the other branches of

*Reference is here made to the work of Dr. Kurt Lewin, of America, in group dynamics.

social life in the hospital, although well aware that it was quite inadequate to deal with the situation alone. There is no doubt that from one point of view at least, this could be considered a great advantage! With the co-operation of the Commanding Officer, administrative alterations were made to allow one large ward to be left vacant for a Hospital Club. The one selected was that adjacent to the Admission Ward. The side-rooms in the corridor leading to the Club entrance were taken over to allow for any demands which might be made upon them. Using the accepted term at the time, a new 'occupation' was opened—a hospital newspaper group. A few interested volunteer patients began with a duplicating machine, accessories, paper—and a debt for the initial outlay of $260.00. At the same time all wards were asked to send two representatives to a meeting in the empty "Club." Although only half the wards were represented, discussions began on the basis of these elementary changes. These meetings continued, supported weekly by a few stalwart patients but it was some weeks, and in some cases, months, before wards were holding regular ward meetings. This did not prevent the committee and the newspaper group from trying other approaches, and gaining ground in the development of activities and Club facilities.

In conclusion, some general remarks must be made, briefly and specifically, in relation to the Social Therapy Staff. Such a staff must be flexible in its structure, sincere and tolerant in its approach; must become quickly aware of problems arising, the psychological and physical barriers which exist or are being set up, and the forces which are being brought into play. It must be prepared to have the courage and patience required in making the primary decision relating to the resolution of inter- and intra-group tensions; is a particular situation one to be left with and faced by the groups or group, or should links be established when there are internal or external factors preventing their formation?

We have learned that the individual must be given every opportunity to develop his own sense of responsibility and inner discipline by gaining a social insight, an awareness that his freedom within the community depends on his interpersonal relationships and a feeling of "belonging." To this end the project method of instruction has proved invaluable and much has been done by emphasizing that reports on patients for the information of psychiatrists should be in socio-behaviorial terms.

Finally, for all groups, whether founded spontaneously or not, whether large or small, it is true to say that the individual contribution has a value only in so far as it has a significance to the community; it is equally true to say that the individual can only experience full freedom and satisfaction in a society that recognizes his worth, and gives him the opportunity to develop in a spirit of warm human relationships.

THE LEADERLESS GROUP PROJECT

By Major W. R. BION, R.A.M.C.

When the War Office Selection Boards were set up it was believed by many that both the supply and the quality of officers was falling off and must continue to fall off as the war went on. There was certainly very little doubt that that belief was true in so far as it referred to the past. But as the senior psychiatrist called in to advise on selection and methods of selection, I pointed out that there was no reason why this statement should be regarded as an axiom. It could be maintained that in a nation at war the supply of leaders could be made to increase and their quality, thanks to the compulsion of national need, could be made to improve. For this to happen selection of candidates would have to be at least as careful as the selection, in forestry, of trees to be converted to timber.

The proposals put forward to bring this state of affairs to pass, over the whole field of selection and not merely at the War Office Selection Boards, were rejected and need detain us no longer. It became necessary to confine our activities to the selection of candidates from among those who appeared at the Boards.

Technique of Selection

The essence of the technique which was evolved, and which has since become the basis of selection techniques in many different fields, was to provide a framework in which selecting officers, including a psychiatrist, could observe a man's capacity for maintaining personal relationships in a situation of strain that tempted him to disregard the interests of his fellows for the sake of his own. The situation had to be a real life situation. The situation of strain, and the temptation to give full rein to his personal ambitions was already there; the candidate arrived prepared to do his best and get himself a commission and, naturally, he feared the possibility of failure. Furthermore this was a real life situation. The problem was to make capital of this existing emotional field in order to test the quality of the man's relationships with his fellows.

This was done by a method so simple and so obvious, when it has been propounded, that its revolutionary nature can easily be lost sight of. The man found he was not entered in a free-for-all competition with other candidates. Instead he found himself the member of a group and, apparently, all the tests were tests, not of himself, but of the group. In concrete terms, a group of eight or nine candidates, an "eye-full" from the testing officer's point of view, was told to build, say, a bridge. No lead was given about organization or leadership; these were left to emerge and it was the duty of

the observing officers to watch how any given man was reconciling his personal ambitions, hopes and fears with the requirements exacted by the group for its success. That, in brief outline, is the basic principle of all the Leaderless Group Tests.

A little consideration will show that the situation thus created is very closely parallel with countless other emotional situations in an officer's life, not even excluding action. For though the emotional tensions in this situation are low compared with those in battle they are nevertheless sufficiently powerful to make all candidates feel that their time at a War Office Selection Board has been a heavy strain despite the interest of the experience and the apparently easy program. It was found that if the testing officers watch what they are meant to watch they have no difficulty in matching what they have found out about a man's personality with what they know will be the sort of job with which he will have to cope as an officer.

It is safe to say that nearly all mistakes arise through failure to keep the selecting officers mindful, throughout all the tests, of the very simple basic principles mentioned above. Either officers tend to interfere, and so distort the field, or else they watch how well the group does any given task. It is important to insist that the actual task of the test is merely a cloak of invisibility for the testing officers who are present; an artificiality intended to explain, and therefore to explain away, the presence of the testing officers. It is not the artificial test, but the real life situation that has to be watched, —that is, the way in which a man's capacity for personal relationships stand up under the strain of his own and other men's fear of failure and desires for personal success.

Parallel Situation in the Psychiatric Hospital

The difficulty which is experienced in teaching officers to watch the real life situation in these selection procedures is unhappily met again in psychiatric hospital practice. An observer with combatant experience could not help being struck by the great gulf that yawned between the life led by patients in a psychiatric hospital, even when supposed to be ready for discharge, and the military life from which their breakdown had released them. Time and again treatment appears to be, in the broadest sense, sedative; sedative for doctors and patients alike. Occupational therapy meant helping keep the patients occupied—usually on a kindergarten level. Some patients had individual interviews; a few, usually the more spectacular, were dosed with hypnotics. Sometimes a critic might be forgiven for wondering whether these were intended to enable the doctor to go to sleep.

It thus seemed necessary to bring the atmosphere of the psychiatric hospital into closer relationship with the functions it ought to fulfill. Un-

fortunately for the success of any attempt to do this, psychiatry has already accepted the doubtful analogy of physical maladies and treatments as if they were in fact similar to neurotic disorders. The apparatus of the psychiatric hospital, huge buildings, doctors, nurses and the rest, together provide a magnificent smoke screen into which therapists and patients alike disappear when it becomes evident that someone may want to know what social function is being fulfilled, in the economy of a nation at war, by this aggregate of individuals.

It must of course be remembered that in a psychiatric hospital there are collected all those men with whom ordinary military procedures have failed to cope. In this brief account it is not necessary to recapitulate in detail the steps taken to deal with this situation. They have already been described elsewhere. But, briefly, it was essential first to find out what was the ailment afflicting the community, as opposed to the individuals composing it, and next to give the community a common aim. In general all psychiatric hospitals have the same ailment and the same common aim—to escape from the batterings of neurotic disorder. Unfortunately the attempt to get this relief is nearly always by futile means—retreat. Without realizing it doctors and patients alike are running away from the complaint.

Group Discussions

The first thing then was to teach the community (in this case the Military Training Wing) to seek a different method of release. The flight from neurotic disorder had to be stopped; as in a regiment, morale had to be raised to a point where the real enemy could be faced. The establishment of morale is of course hardly a pre-requisite of treatment; it is treatment, or a part of it. The first thing was for the officer in charge not to be afraid of making a stand himself; the next to rally about him those patients who are not already too far gone to be steadied. To this end discussions were carried out with small groups. In there the same freedom was allowed as is permitted in any form of free association; it was not abused. These small groups were similar in organization and appearance to the Leaderless Group Tests, known as group discussions, which had already been used, though for a different purpose in the W.O.S.B.

As soon as a sufficient number of patients had in this way been persuaded to face their enemy instead of running away from it, a daily meeting of half an hour was arranged for the whole training wing, consisting of between 100 and 200 men. These meetings were ostensibly concerned only with the organization of the activities of the wing. The wing by now had been split up into a series of voluntary groups whose objects varied from learning dancing to studying the regulations governing army pay. In fact the problems

of organization, of course, hinged on the problems of personal relationships. Lost tools in the handicraft section, defective cinema apparatus, permission to use the local swimming baths, the finding of a football pitch, all these matters came back to the same thing, the manipulation and harmonization of personal relationships. As a result almost immediately these big meetings as well as the small ones, spontaneously became a study of the intra-group tensions and this study was established as the main task of the whole group and all smaller groups within it.

Study of Tensions

Thus occupational therapy had been given a new meaning. The therapeutic occupation of the group was the study of the tensions within itself. It was not basket making, or learning to swim, or carpentry, or studying army pay, even though such activities might, and often did, bring relief.

It was a result of this therapeutic activity that the group began to think, and a deputation voiced the thought, that 80% of the members of the training wing were "skrim-shankers," "work-shys," malingerers and the rest, and ought to be punished. A month before the training wing had complained indignantly that inmates of a psychiatric hospital were regarded by the rest of the community as being just these things. It was disconcerting, but a revelation of what psychiatry could mean, when the psychiatrist refused to accept this wholesale diagnosis, and simple proposal of punishment as the appropriate form of therapy, as a sound solution of a problem which has troubled society since its commencement. The therapeutic occupation had to be hard thinking and not the abreaction of moral indignation. Within a month of the start of this metier these patients began to bear at least a recognizable resemblance to soldiers.

Guiding Principles

Throughout the whole experiment certain basic principles, believed to be absolutely essential, were observed. In order of their importance they are set down here even though it involves repetition.

1. The objective of the wing was the study of its own internal tensions, in a real life situation, with a view to laying bare the influence of neurotic behavior in producing frustration, waste of energy, and unhappiness in a group.

2. No problem was tackled until its nature and extent had become clear at least to the greater part of the group.

3. The remedy for any problem thus classified was only applied when the remedy itself had been scrutinized and understood by the group.

4. Study of the problem of intra-group tensions never ceased—the day consisted of 24 hours.

5. It was more important that the method should be grasped, and its rationale, than that some solution of a problem of the wing should be achieved for all time. It was *not* our object to produce an ideal training wing. It *was* our object to send men out with at least some understanding of the nature of intra-group tensions and, if possible, with some idea of how to set about harmonizing them.

6. As in all group activities the study had to commend itself to the majority of the group as worth while and for this reason it had to be the study of a real life situation.

The Psychiatrist's Problem

One of the difficulties facing a psychiatrist who is treating combatant soldiers is his feeling of guilt that he is trying to bring them to a state of mind in which they will have to face dangers, not excluding loss of life, that he himself is not called upon to face. A rare event, but one that does occur, is when an officer is called upon to stop a retreat which should not be taking place. His prominence at such a time will certainly mean that he will be shot at by the enemy; in extreme cases he may even be shot at by his own side. Outside Nazi Germany psychiatrists are not likely to be shot for doing their job, though of course they can be removed from their posts. Any psychiatrist who attempts to make groups study their own tensions, as a therapeutic occupation, is in today's conditions stopping a retreat and may as a result be shot at. But he will lose some of his feeling of guilt.

In conclusion it must be remembered that the study of intra-group tensions is a group job. Therefore, so long as the group survives, the psychiatrist must be prepared to take his own disappearance from the scene in not too tragic a sense. Once the rout is stopped even quite timid people can perform prodigies of valour so that there should be plenty of people to take his place.

THE TECHNIQUE OF GROUP THERAPY

By Capt. MILLICENT C. DEWAR, R.A.M.C.

Before entering upon any description of the technique of Group Therapy we must study the different ways in which a group may be formed. We have firstly those of the patients who have been admitted together and formed into a group from the beginning with or without individual therapy and secondly there are those formed after some individual therapy; these are "closed groups" in that no new patients come in after the first session and the group breaks up when they are discharged from the hospital. Thirdly, there is that group which may be termed "open" in which patients are continually coming in and going out, thus giving a continuity of the group but not of the participant individuals. This last type is the least typical but has often to be used, as the admission and discharge rate cannot tolerate the rigidity of the first two methods. Most patients are suitable for group therapy but although in this stage of our experience it would be difficult to lay down arbitrary rules, the following do *not* appear to be so: the very depressed, who in an experimental group showed that the essential disintegrating qualities of their aggression broke it up; and those who are mentally dull and find it almost impossible to verbalize their thoughts.

Preliminary Arrangements

The actual handling of a group is difficult to describe. It must of necessity vary from psychiatrist to psychiatrist and can have no rigid doctrine applied to it. It has been found best to have the men in a smallish room sitting in as near circular formation as possible. This would appear to create the optimum situation for exchange of feeling and ideas. Group sessions running coincidentally with individual therapy are usually held once a week but where they are the only form of treatment they are run twice or thrice weekly.

The beginning of the first session can be attempted in different ways. The patients may be told beforehand that they will discuss their personal problems as freely as possible, or without any previous preparation they may be put together and in the first meeting challenged by the psychiatrist. To my mind the ideal group is one in which patients have been admitted together and have worked as a group from the beginning; they are immediately confronted with the problem of discussion and have the minimum of individual contact with the psychiatrist.

The Function of the Psychiatrist

The next matter for consideration is the rôle of the psychiatrist, who inevitably has a different function from that of other members of the group.

He holds in their eyes a position of authority and they to him are inevitably patients. It is essential, however, that his interest in them must be directed to the group and not toward the individual in the group. That is to say, the ordinary psychiatrist-patient transferance situation must be at a minimum, otherwise from time to time it cuts out members and so disintegrates the "group feeling."

There is usually difficulty at a first meeting, for the patients are unfamiliar with the situation and the psychiatrist is confronted with his first problem; an uneasy tension slowly rises and he must decide how long he should allow it to go on. In our hospital where patients never stay longer than three months and usually a shorter time, it is our practice to break the tension after an interval of about five minutes. If it is not broken soon, deep unconscious trends begin to emerge with which in the short time at our disposal it might be difficult or impossible to deal.

In the main the breaking of the tension may be done in one of two ways; the psychiatrist may throw in a controversial remark or he may query the actual silence itself. This usually starts a flow of superficial talk, and in early sessions the general rule is to allow the conversation to remain on this level so that the patients get to know each other; the next session opens with a consequently lower group tension. There are, however, exceptions to this rule which illustrate the fact that the prime moving force in this is in the group itself. (Recently a group treated from the beginning as one, brought out at their first meeting deep feelings of guilt about having been taken prisoner of war. They have since returned to it at other sessions and have gained a great deal of insight into the problem. This depth at a first meeting is, however, rare.)

As the sessions go on the group usually tackles more personal and complex problems and the degree to which it does this is most impressive and satisfying. It is common to get a man who has no insight whatsoever into his own problems solving others similar to his own in another member of the group. When this has gone on for some time the psychiatrist may put in a pointer to illuminate the situation which has developed between the two men.

Therapeutic Guidance

The psychiatrist should help to bring out of many remarks and trends of conversation some central guiding principle and conclusion. Where for instance a general drift of conversation has been going on about the generally bad characteristics of sergeants and officers, the dislike of rules and regulations, a word or two would be needed as to the underlying cause for this general dislike of authority and authoritarian figures.

It cannot, however, be emphasized too often that the psychiatrist must

not dogmatize or dominate his patients. If he is too eager to speak the group immediately becomes an audience and their peculiar inter-personal relationships are destroyed. This should not blind him, however, to the times when his comments can be powerfully therapeutic for the group. Occasions arise in a group meeting where the arguments begin to go round in ever widening circles and a feeling of distress and insecurity can be felt to rise within the group because they see no hope of any conclusion being reached. Here it is essential that the psychiatrist accept responsibility as a parental figure and makes his presence felt by giving an explanation, a word of reassurance or even a word of ridicule. This at once restores a sense of group security and the patients are able to go on with the search for a solution of their problems.

Problems of Assimilation

Some more specific situations are caused by the man who sits silent. It is better to allow the group itself to treat this man for almost invariably they will bring him into the conversation. If, however, they do not manage to do so after several sessions, it is necessary for the psychiatrist to draw him in by some remark addressed to him, in relation to the rest of the group. There is also the problem of the anti-social or schizoid person in the group who is turned upon by the other members. The psychiatrist must in this instance probe the rest of the group as to the reason for their attitude to this man. Otherwise in a case like this the group is merely playing the part of a rather stern jury with very little understanding and is not therefore therapeutically helpful to the man.

There is much that might be said, but in a short article the main point which needs stressing is that the psychiatrist should play a "passive" undidactic rôle, easing tensions and interpreting in a way determined by the emotional needs of the group.

PRINCIPLES AND PRACTICE OF GROUP THERAPY

By Major S. H. FOULKES, R.A.M.C.

Instead of sitting alone with one individual patient, the therapist may call a number of them together and talk to them. In a military hospital, for instance, there are many things which he may wish to convey to all his patients together, or to a whole ward. In such a situation he would talk differently than when talking to a patient alone. At the same time, if encouraged, they will talk back and also to each other.

One of the first things the therapist will notice is the general atmosphere. His patients may appear obediently or curiously expectant, bored and apathetic, good humored or tense with anxiety, adversity and hostility. The conductor will become aware of their predominant attitude towards himself. He will sense, for instance, whether and in what way his presence influences the picture. This may be due to the sort of person he is, what he may or may not do, what he has to say and how he says or does it. He will be observed by the group, scrutinized and summed up, quickly and precisely, as by common consent, yet by intangible ways of perception and communication.

Meanwhile his own observation of the group becomes more detailed also. The patients are not a uniform body. Sometimes they are in good agreement, sometimes sharply split and clashing over an issue only to march in perfect unison a few minutes later. They may be with him, or against him. Many of them stand out from the main body, and gradually all of them acquire individual characteristics. Some are absent altogether and others keep out of range choosing their seats behind the therapist: Some sit aside in isolation; some are at ease while others are tense and preoccupied. Some are attentive while others talk, and here and there is a man persistently unconcerned about what is going on, while another is restless and fidgety. A man, sitting in a corner, suddenly, as if awaking from sleep or out of a dream, makes a sarcastic remark or voices violent opposition, or shoots off at a tangent; another, who had not spoken yet and remained undefined, unexpectedly sums up a whole discussion humorously, follows this up by one or two constructive proposals and alters the whole situation.

The Group Functions

The psychiatrist listens and mentally registers. His "patients" have become alive, acting in a reality which he can share with them, under his own eyes. He need no longer rely on their own accounts and descriptions, based on self-observation and introspection, with all their fallacies, but can see for himself how they behave, feel and react, where they fail or are ham-

pered by their disturbances. If he is in a position to check this against other observations, he can convince himself of the significance and reliability of this display. He is then fully justified in attaching importance even to the smallest detail observed. Frequently a patient shows up quite new facets, which the psychiatrist can follow up with further observation and inquiry.

Thus a first contact is established. It is a mutual contact. The therapist need not be afraid of this searching test, unless he could be credited with bad intentions. All he need be is honest. Pretence and acting would not go far. Nor is there need for them for the group psychotherapist is not concerned with making a good impression, with being liked or disliked. By this first mutual contact a community of feeling has been experienced by the patients among themselves, as well as in relation to the therapist, and in addition embracing the whole little community, therapist and patients together. The importance of this cannot be overrated. While in itself a potent therapeutic agent, in particular against a background of the usual pre-existing apprehensions and misapprehensions, it is the indispensable matrix for other therapeutic steps. If the therapist is open and sensitive to this contact, meets his men more often and regularly in this way, he can learn to play on them at will, as on an organ, and could on this basis alone lead them almost anywhere, if that were his task.

The Art of Leadership

This, however, is not his task in a psychiatric hospital where the patients' difficulties are essentially of such a nature as to prevent them from standing on their own feet and grappling with their own problems. If the psychotherapist resists the temptation to be made a leader, he will be rewarded by their growing independence, spontaneity and responsibility and personal insight into their social attitudes. It happens in exact proportion to the psychiatrist's art of making himself superfluous. He can, however, resign only from something which he is strong enough to possess, and if there are doubts as to his capacity for leadership, he had better accept this function offered to him until such time as he is quite certain and secure in it. He must not hesitate to lead when the situation demands it.

The ward is the patient's temporary home and surround, his refuge from that strange and bewildering turmoil, the hospital. Here he meets his pals with whom he is to share the ups and downs of his present life and, more or less intimately, the experiences of the past and the worries at home, his and theirs. These are the people with whom he will talk on lonely walks and after "lights out" at night. The spirit which permeates the ward, and which the psychiatrist must foster, is thus of the utmost therapeutic significance. The ward has another function: that of a bridge between the

patient and the hospital. It occupies a definite place and has an active, responsible and powerful part to play in the hospital. As a member of the ward, the patient shares in this, he begins to realize that the hospital is his, is what he makes out of it, that he is the hospital.

The Psychotherapeutic Group

More is needed, however. The patient needs insight; insight into his own inner condition and life, insight into his present feelings, behavior and reaction. Therein lie the limitations of a large meeting (30–80 men): The patient's reactions, cannot be brought to light, voiced, described, realized or brought home to him by others. For this a more intimate setting is essential. Seven or eight people at a time have proved a good number. They meet regularly about once to 3 times a week, for a set period of 1–1½ hours, in the presence of the psychiatrist, in order to discuss anything they wish. Strong interpersonal relationships develop and features of an organismic structure become more and more evident. This type of meeting we call a psychotherapeutic group. The psychiatrist leaves the lead to the group, acting mainly as a catalyst and observer. The individual participant produces himself or his ideas for the group, acting also as receiver and audience when he takes an active interest in the others' problems.

If the conductor sees to it that each member participates as fully as possible in these various functions and does not neglect to watch and treat the group persistently as a whole as well, it will soon become a self-treating, self-propelling and progressive body. He will be better able then to observe and steer the group unobtrusively—more towards this problem or that, towards one patient or another's needs, and generally towards psychological levels which he deems desirable or for which he feels fit. In such a group the individual is thrown into high relief and the greater the psychiatrist's experience and skill, the less will he find it necessary to relegate so-called personal problems to supplementary individual interviews.

Selection Factors

No particular selection of patients is necessary for this type of group, but all sorts of selective principles can be interestingly and usefully applied. All that is desirable is to avoid too striking a disparity in such factors as intelligence, age, past Army experience and prospective disposal. It is equally undesirable to put individuals into a group who from certain factors are bound to be sharply separated from the group's other members. Where possible, a common general background is desirable. Such a group can be left "open": that is, as older patients leave the hospital newcomers take their place in the group. It is desirable that there should always be a representative number, say two-thirds, present who have been together for

at least four weeks, if continuity is to be maintained. Alternatively, once established, it can be conducted as a "closed" group, keeping its composition unchanged until disbanded. This has many advantages, especially if the same group undertakes a group project together as well, and if the time of stay in hospital is altogether short. The stronger bonds thus established outweigh the possible disadvantage of inbreeding, and weaning especially as in spirit and orientation every group should be "open."

Many of the socializing and therapeutic factors become operative in the same way in the groups which have been extensively developed at this hospital to carry out group projects. Indeed they form their essence. But unless a skilled observer can be always present with the "Selected Activity" group and report to the psychiatrist concerned, these forces operate blindly and there is not the same opportunity, as there is in the therapeutic session, to make the patients aware of what is going on.

The therapeutic session is, in a sense, a "Selected Activity" as well: that of learning to talk, express and listen to opinions, discuss matters of interest and so forth—an important social activity. The relationship and mutual penetration of these two fields of observation, artificially separated as *psychotherapy* and *social therapy*, is a fascinating study as well as of great practival importance. It could be said that a group has boundaries like a membrane of variable permeability. If the hospital milieu is opposed to the spirit prevailing in the group, if the osmotic pressure is high, these boundaries harden and become more selective; if the spirit inside and outside is in harmony, they may almost or completely disappear. This is another most important and more specific link between the hospital and the patient, and the more the hospital as a whole becomes a therapeutic field, the more can it become the main function of the psychotherapeutic group to activate and prepare the patient for the impact of the hospital community upon him and in turn to work out with him the stimuli thus received. This puts the emphasis of treatment not upon past history but upon the immediate present—a desirable shift where time is short—and one of the most important aspects of this approach.

Group Dynamics

As far as the individual is concerned in group therapy he finds himself in others and others in himself, by similarity and contrast, thereby regenerating to some extent his ego and its boundaries. At the same time the group is a potent modifier of the superego and liberator of the id, symbolizing, as it does, the community, and in the last resort being unconsciously understood by the group in its archaic significance. Group dynamics are not within the compass of this paper. They are manifold and seem to work with great precision. There is no doubt that they can be used as therapeu-

tic vectors of great potency. Much of this is still empirical and intuitive, but one cannot escape the impression of a quasi-mathematical precision, best perhaps to be expressed in terms of Field Theory.

It has been possible within this framework to assign a number of psychiatrists and practitioners, without selection and for the most part without much preparation, to groups, or rather, assign the groups to them, without doing any harm, to say the least of it. There is general agreement that it does them, as well as their patients, a lot of good. With increased knowledge, the framework becomes more and more precisely adapted to the purpose. It leaves the individual conductor free to choose a style and range of group psychotherapy appropriate to his experience, skill, and the degree of rigidity in his own make-up, etc. His approach will in any case be reflected in the group, and as he is himself thrown into the group as well, this acts as a mutually self-regulating procedure. This has helped matters a great deal, since our task at Northfield Military Psychiatric Hospital is to devise methods as simple as possible so as to be applicable as broadly as possible. A note of warning may be permitted here: not to connect "Group Therapy" as such with a notion of mass production. It is not a sausage machine! Within a different framework and with more ambitious aims, it is an instrument so delicate and yet so powerful, that its skilled handling demands more from the therapist than the most difficult individual analysis.

One of the ways in which the individual psychiatrist's position tells, is expressed in what he feels he can handle in a group or individual session respectively (and here again he will choose the right proportion for himself). Individual sessions are partly supplementary, partly antagonistic to the group, at least as long as the approach is not "wholistic" in the therapist's mind.

The writer's practice at Northfield, from considerations both of experiment and expediency, has been increasingly towards putting the group into the center, even in the individual interview where necessary, and shifting the emphasis from the smaller group of the consulting room towards the ward and the hospital as a whole, and in the last resort—from all levels—towards the community. This was possible since the hospital as a whole became more and more a therapeutic field and since he knew that, while digging a tunnel from one end, he would be met halfway by workers from the other end—in other words, that the general hospital activities were directed with the same basic idea and identical intentions.

NOTES ON A GROUP OF EX-PRISONERS OF WAR

By Major SUSAN DAVIDSON, R.A.M.C.

These notes of the progress of a group of ex-prisoner-of-war patients at Northfield Military Hospital are given in the manner in which they were recorded and without censorship or comment. They were compiled from memory after each group meeting.

This group of N.C.O.'s was selected by the psychiatrist who referred them to the hospital for treatment, and were all intelligent and of good personality, but they present a fairly accurate picture of how a group of ex-prisoners with repatriation problems behaves in a neurosis hospital.

Members of the Group

(1) *Cpl. J., 30 years.* A chauffeur in civil life, happily married with one child. Had always been a stable, responsible personality who got on well in civil life and in the army. Served in the Middle East and taken prisoner in 1942. He was very roughly treated by the Italians, many of his pals died from starvation and he was too weak to do more than lie on his bed most of the day. He was sent to Germany 2 weeks before the Italian capitulation and was on a forced march for 6 weeks when he developed dysentery and coughed up blood.

On repatriation he could not stand noise, settle down or mix with people and had a horror of returning to the army, being on parades etc.

(2) *Sjt. C., 26 years.* A dispenser in civil life, with a stable, mature personality. He had some depression and headaches for a time after battle experience in 1940 but these were never sufficient to report sick. He went to N. Africa in Jan. 1943 and was taken prisoner in March. He went through very severe privations but remained well till the severe bombing of Vienna in 1945, when he became tense and jumpy and suffered from battle dreams. On return to this country he found his wife very unhappily situated, living with a difficult aunt. She became pregnant during his repatriation leave and he then found that she had congenital syphilis. He was very nervous and states that he could barely speak and was admitted to hospital for malnutrition and catarrhal jaundice for a month. While on leave he had to hold on to himself, was very depressed and frequently wished he had never come back.

(3) *Cpl. M., 30 years.* A driver in civilian life. He went to the Middle East, Nov., 1940 and was taken prisoner in June, 1942 in North Africa, after severe battle experiences and heavy bombing in Tobruk, to which he appears to have reacted well. He was restless as a prisoner owing to inactivity, but his main symptoms came on only on return to this country when he became tense and depressed with poor sleep, lack of concentration and a tendency to anxiety attacks in cinemas. He felt that the transition from prison life to home (since they were evacuated by air) was too rapid, and

did not give them sufficient time to adjust to the change. He was a previously stable man who always showed a mature and balanced, outlook, and though quiet, he took an active interest in the group and got on well with all the other members.

(4) *Cpl. B., 23 years.* He was employed as an upholsterer for 18 months before joining the army in June 1939. His home life was an unhappy one as his mother drank and quarrelled with her step-children, but he does not appear to have had any previous nervous instability. He was taken prisoner in March, 1944 at Anzio after his unit had been badly cut up and most of the others were killed when hand grenades were rolled down on to them. He was only scratched but felt too shaken to walk when taken prisoner and felt that he had "let someone down" by being captured. He was in a prison camp in Italy for 4 months with very little food. They were sent to Germany in a cattle truck and 5 men escaped. The rest were then lined up to be shot but were beaten up with rifles and bayonets instead and made to sit on their haunches all night. For a time he had recurrent dreams of this experience.

On return to this country he found his eldest step-brother, to whom he was particularly attached, had been killed in a mine-sweeper. He was irritable and depressed on admission, with poor appetite and concentration, and had great difficulty in mixing with the others.

(5) *L/Cpl. H., 25 years.* Employed as a steel-shearer until he joined the army in 1933. He served in France and the Middle East and was taken prisoner in June 1942. He had a very hard time as a prisoner and had to work down the mines in very dangerous positions. After 3 months he became nervous and depressed and lost weight. When liberated he felt no more interest in anything; "There was no more reason to keep yourself alive." On return to this country he had difficulty in settling down and mixing with others and felt unable to enjoy himself. His parents keep a public house and the father has been crippled since the last war. They tend to treat him as a child but throw a great deal of responsibility on to him and are now relying on him to run their business for them. On admission he was tense and somewhat depressed, restless and complaining of mild claustrophobia.

(6) *Pte. T., 28 years.* A painter in civilian life, he served in the Middle East and was captured in June, 1942. He was a prisoner in Italy for 18 months and then was transferred to Germany. He was in hospital for a month with his chest and has a slight chronic bronchitis. Towards the end of 1944 he became depressed and unable to sleep or concentrate. He improved at first on repatriation but relapsed on being sent to the Selection and Training Battalion.

He joined the group late and always remained somewhat timid and retiring, though he was popular with the other patients, taking a very active part in the group project, and went about with other members of the group.

(7) *Cpl. H., 26 years.* Joiner and professional footballer until he joined the army in 1939. He had a depressive illness at the age of 18, when he was

off work for several months and had thoughts of suicide. He has always been subject to mood swings with periods of elation, when his brain felt extremely clear and he was able both to enjoy himself greatly and to create enjoyment for others, followed by phases of depression. All the family are emotional and the mother has marked mood swings.

He was taken prisoner in 1940 and had a few short periods of depression. On return to this country he was exhilarated and above himself for a month and then depressed, felt something was lacking and everything was futile. He was mildly depressed but was not retarded though he had poor concentration. He was a skilled joiner and worked very conscientiously in the group, but he always remained somewhat solitary, although he took a fatherly interest in L/Cpl. H.

Formation of the Group

The group originally consisted of 6 N.C.O.'s of good personality who had all been under considerable stress. None of them had any history of previous nervous disability apart from the manic depressive, who had had a previous depressive attack. All of them exhibited symptoms of reactive type but none of them appeared to be suffering from a true neurosis.

Cpl. J. was very agitated, emaciated, restless and intolerant of noise and was separated from the rest of the group and placed in a sideroom in William Ward and given sedatives. The others remained in the Admission Ward for the first few days. They were all tense, depressed and irritable with poor sleep and appetite. One of them claimed: "I am looking for something, but I don't know what."

The first group meeting took place on Aug. 29, 1945. None of them had yet been interviewed apart from a five or ten-minute period on the previous day and all were dressed in Hospital Blues. They all appeared depressed and were tense and irritable though co-operative and eager to get well.

It was explained to them that they were now formed into a group, and would remain together and receive the same treatment during their stay in hospital. They were told that groups were formed because it has been found that they assisted patients in their recovery. This was their own group and they were free to talk about anything that they liked and to direct their meetings as they wished.

First Meeting

Cpl. J. opened at once with a somewhat aggressive request to know if it was essential for them all to wear hospital uniform, and there followed a lively discussion about feeling "marked men" and of how this revived memories of the patches they had had to wear as P.O.W.'s. (They appeared to feel even more strongly about this than the average patient.) They then spoke of the irritation which the "Out of Bounds" notices and the presence of guards patrolling the back entrances to the hospital produced. They

felt that they had only to look outside to feel at once that they were back in the *stalag* again. They asked for permission to go out whenever they wanted for a walk in the lanes and fields. They said that they would not cause any trouble and would be back at the time requested, but they felt a great need to be able to go out at their own free will. No very satisfactory answer could be given to this though they were promised that the question of wearing their khaki would be raised and they would be informed about it later.

Conversation then died down into a somewhat tense silence.

When asked what were the difficulties which had brought them here, they spoke freely of their inability to fit in on return to this country and of the difficulty in finding any topic of mutual interest. The only thing they knew anything about was P.O.W. life and of this they had no desire to speak. They described the tremendous urge to do something useful and constructive.

What appears to have precipitated the breakdown in them all was the complete frustration and uselessness of the three weeks they had spent at a Selection and Training Battalion after repatriation. They described it as a dark and clammy place, shut in by woods, so that they rarely saw the sun and where they were continually reminded of their prison camps in German forests. They were given a recruit's training from N.C.O.'s who they felt knew far less than they did about the subjects they were teaching. One lecturer told them he was only there to fill in time and an instructor said no doubt they wondered what was the point of the training they were being given and admitted that the instructors were equally in the dark.

They were all tradesmen who had jobs to return to, and they felt keenly the waste of their time and ability. Many of them were connected with the building trade and their former employers were crying out for their assistance, in view of the acute housing shortage. Cpl. J. stated that he had not only a job but a house waiting for him if he took it within 6 weeks.

While at Pipers Wood they were shown war films which had upset them all considerably. (They did not, on this occasion, enlarge on this subject. It appeared to be too painful to discuss.)

Finding a Project

The second meeting took place on Aug. 30, 1945, and Major Bridger of the Social Therapy Staff was also present. This was a short meeting to discuss a group project. The group included a joiner, several carpenters and an electrician and they discussed various schemes. They decided they would like to work for a childrens' clinic but that each of them would also like to make something to take home. They agreed to pool their abilities in these undertakings as well.

The following day they had a discussion with Major Bridger and Dr. Creak, when they were told something of the work of Child Guidance Clinics and the type of toys required. (I was unable to be present at this meeting.)

On Sept. 2 they appeared to be improving. Cpl. J. had now settled down, was sleeping better and taking his meals in the ward with an improved appetite.

They described Birmingham as a dead city; several of them went in on the previous day (Sunday) and wandered about, finding nothing of interest, so they came back. They discussed the group project they were about to undertake and had now decided that they would make a model village, including houses, a church, trees, etc., for a sand tray, and a four-roomed doll's house without a roof, for the Gt. Ormond St. Child Guidance Clinic. They appeared to have all their plans cut and dried; Cpl. H., the joiner, was to do the joinery, several of the others would do the carpentry and L/Cpl. H. (who had no special skill) was to do the painting. They were keen and confident of their ability to carry out the work. For the present they were not interested in the things they had planned to do for themselves but wanted to do something straight away for the Clinic.

Fourth Meeting

The fourth meeting was on Sept. 5, 1945. There was a marked improvement in all the members of the group. They were now all up in William Ward and Cpl. J. had improved so much that he was able to leave his small room and join the others in the dormitory and go with them to meals in the dining hall.

They were now all wearing khaki. They were informed that they would all be brought before a medical board and boarded out of the army. (They were in low point groups and it was considered better for their own recovery that they should be left in no doubt as to what was to happen to them.) They had now to recover sufficiently to take up their civilian jobs. They expressed great relief to know that they would not have to go back to the frustrating conditions they had experienced prior to their admission. Cpl. J. who would now be able to secure a house as well as a job, showed particular relief.

They began to discuss their life as P.O.W.'s and of the many methods they had employed to outwit the Germans. They described how the Americans were apt to "let go" when taken prisoner; they did not wash, slept in their boots, etc. A certain amount of feeling against Americans was expressed; they wondered why Americans behaved in this way, why American girls became "hysterical" over crooners, etc. They asked a lot of questions about Child Guidance Clinics and they considered Birmingham backward as it had only one clinic. (There was some confusion in their minds be-

tween Infant Welfare and Child Guidance Clinics.) They described what they were doing in the occupation huts, how they had already made several of the houses and of what they intended to do—making a school and shops, etc. They then said that another man who was an expert painter and who had been with one of them in a prison camp and had come with them on the same day to this hospital from Pipers Wood, had joined them in their project. They also stated two others had come with them—one of whom was already being boarded out and the other they referred to as "Blondie," but they showed no great enthusiasm that he should join in with them, but readily accepted the idea that the painter should become a member of the group.

Pte. T. was sought out and his transfer arranged so that he became a member of the group from this time onwards.

The Group Moves

Between the meeting on September 5th and the next one on September 9th, several events occurred. The group as a whole was transferred (with the rest of my patients) to Charlotte Ward, but were with a party of 13 in the bay portion of the ward, with whom they formed a small community somewhat isolated from the rest of the ward. Pte. T. had now taken on all the painting in the model village and L/Cpl. H. was deprived of his task. He became very much isolated from the rest of the group, went about by himself, came in late and was on several charges. He was admonished but was also made to give up his khaki. This he felt to be unfair since this was a greater punishment than the admonition.

At the fifth meeting on September 9th they all showed a continued improvement. They expressed approval of their new ward "because no one bothers you." They did their own cleaning and tidying, without anyone questioning their ability or inability to cope with it. All 13 were good friends but they disclaimed any interest in the rest of the ward and were still playing football for William Ward. Cpl. H. asked what would happen if they were not all ready to leave the hospital at the same time. He realized it would be upsetting for anyone to be left but were he himself that one, he would hate to feel he was keeping the others back. He was reassured that the group would not be retained for the benefit of any one individual but that in all probability they would be well enough at the same time.

A discussion took place about the Jews, and Cpl. J. expressed his feelings of dislike towards them quite forcefully, but several of the others pointed out that there were many great things which the Jews had done. They then discussed the Italians, how very primitive they were, their very poor

living conditions. Cpl. B. described Italian farmhouses where there were no lavatories and the Italians just "used any part of the surrounding country." They discussed differences between German and Italian food and stated that the German bread was very good and very sustaining. They were now able to discuss events of their P.O.W. life cheerfully and with much communal interest and friendly reference to mutual acquaintances in the different camps. Pte. T. remained shy and rarely spoke but was occasionally referred to by the others, when he joined in monosyllabically, but in spite of this he took an active interest in everything that was said.

Individual Difficulties

I called their attention to the fact that one of their members, L/Cpl. H., had lost his khaki, that this must have some effect on the feelings of the rest of the group. In tones of friendly badinage they stated that they had taken him in hand and would put chains on him, if necessary. Cpl. H. now adopted a paternal attitude towards L/Cpl. H. and had apparently taken him to work with him in constructing the doll's house. The L/Cpl. sat there, smiling somewhat self-consciously, but was obviously pleased to be taken back into the group. They went on to talk about an entertainment which had occurred one evening in the hospital and one of them banteringly turned to him and said: "Of course, you wouldn't know; you have never been in, in the evenings." They asked about the possibility of leave and were told that they could have 4 days (48 hours and 2 V.J. days) at the week-end if they would like to have it, and they all agreed they would like to go the following week-end, except Cpl. B. whose wife would not be free until the week-end after that.

Cpl. B. remained depressed and considerably worried after seeing the Medical Specialist. He was found to have a raised blood-pressure and signs of early arterio-sclerosis. The blood Wassermann came back positive but there was some doubt about the validity of this report and two subsequent reports were negative. No definite information was given Cpl. B. until the final reports could be obtained and it was difficult to allay his anxiety about his physical condition. He had been told that he must not play games or take part in any strenuous activity and he feared that he might have difficulty in getting into the Police Force on his discharge.

The sixth meeting took place on Friday, 14 Sept., when Lt. (Miss) Hussey was present. L/Cpl. H. stated that he was on a charge again for being out late and wondered if he would be permitted to go on leave that afternoon. The group then discussed the difficulties in getting in by 9.30 p.m. L/Cpl. H. had to leave and the others then discussed the fact that it was impossible for them to keep him out of trouble—that he was always coming in late and invariably came in through the Guard Room so that he was caught, instead

of in through the back ways, as the other patients did. When asked if they knew of any reason why he might be doubtful over wanting to go on leave, they stated there was no reason at all but described the details of his family life, which certainly gave room for plenty of ambivalence. (His family kept a "pub" but the father was ill and they expected a great deal of their son and placed heavy responsibilities on him.) They continued to discuss disciplinary difficulties and the problem of being in by 9.30 p.m. but appreciated that there were some who needed an additional amount of sleep. Cpl. J. described how two men on the previous night had come in late with an organized party but had taken off their boots and come in on tiptoe, which had impressed him with their thoughtfulness for others. They stated that, considering the number of P.O.W.'s we had here, they were surprised that we did not get more disciplinary problems. They were all looking forward to their week-end, Sgt. C. said he did not think they would come back, but Cpl. M. hastened to assure me that they would all return.

At the next meeting, September 21st, they had all enjoyed their leave and all returned on time. Cpl. B. was reassured about his physical condition and was due to go on leave that day. All of them showed very great improvement and were now asked to describe what they felt had gone wrong that had led to their coming into the hospital. They stated that when they were freed they still felt that they were in a rut. They had looked forward to peace so much and when it came they were disillusioned. They felt listless; though they wanted to come to England they did not know what to do when they got there. When they were released they went out and got food and were more interested in that than in their release.

Prison Experience

Their experiences in prison camps had varied somewhat. Some had remained well; others were very emaciated. Two had been on a forced march lasting 2 months but others had been on farms where the food situation had been better. On their return they felt "cheesed off" with everything—irritable and restless. They wanted to be on their own and felt self-conscious. One of them stated: "In Germany I was a stranger and you felt it was natural that people looked at you, but when I came back I felt they were looking at me more. I couldn't sit still and I couldn't go into a cafe." One of them stated: "There is a childish vanity in us all. As prisoners we felt downtrodden. When we came back we were just like anyone else but we felt we should have been given sympathy as a prisoner." Cpl. H. felt that they were given too much sympathy and that that made them worse. They felt that they were getting something on false pretences. They did not deserve it and they stressed the fact that while others had been in action, they themselves had been merely a liability to the country. They

also had some guilt over having had to work for the enemy tho' they used to do as little as possible and would even go without fires in their huts, rather than go out and get firewood which might release a woodman who could then go to the front.

They discussed how the P.O.W. had a contempt for rank. In the camps men used to put up stripes and crowns because no one over the rank of full corporal was forced to work. Among themselves they never knew who held a rank rightfully and who by "*stalag* promotion." They discussed the question of escapes and said that no one had a chance unless he could speak German. If you were caught or if you were difficult, you were sent to concentration camps. Cpl. J. commented on the fact that we heard a great deal about the conditions of Belsen and the German Concentration Camps but that the Italians had Concentration Camps which were every bit as bad and of these we heard nothing. He went on to describe the South Africans as "bad men," that they were responsible for the fall of Tobruk and had been all ready to hand over. Someone else stated that the First Division of South Africans was O.K.—they had "put up a good show."

One of the worst features of their camps had been the lack of occupation. Those who had been occupied had got on very much better. When they got back they expected to be demobilized at once and their first thought was to get on with something "useful."

The group continued to improve and became gradually more and more dispersed among the rest of the ward and hospital: though they remained very friendly, they showed ever-widening interests and appeared no longer to need the security of a small group. Cpl. M., Cpl. J., Sgt. C. and Pte. T. remained more or less together and Cpl. H. and L/Cpl. H. occasionally joined forces, but Cpl. B. remained very much on his own. Cpl B. had considerable guilt and felt that he ought to have been killed rather than taken prisoner. They finished their group project, the model village and doll's house for the Gt. Ormond St. Clinic, and most of them undertook some project, such as a toy or handbag, to take home.

A marked change occurred in L/Cpl. H. after he was elected a ward representative during a ward meeting. He was no longer out late and there was no further disciplinary difficulty and he became a very conscientious and responsible ward representative. He now appeared to have found a niche in the social system, where he was a valuable member of the community and no longer just accepted in the group by the kindly toleration of his more skilled colleagues.

On Oct. 2nd they all appeared before a medical board and were placed in Category "E". Cpl. H. still showed some tension and slight depression but the others had settled down well and showed no overt anxiety. Cpl. J., in particular, showed an enormous improvement—his face had filled out and he had lost his irritability and much of his intolerant attitude.

Post-Prison Experiences

Their last meeting was on Friday, October 5th, when Major Foulkes was also present. The first part of the meeting was taken up in collecting the facts about their stay at the Selection and Training Battallion after they were returned to this country. They had all of them broken down there and an official complaint about their treatment was to be sent up to the War Office. They described how they were shown Japanese atrocity films with close-ups of civilian women being shot and living prisoners being used for bayonet practice. Also the bombing of a Chinese city, with the people running in all directions, trying to get away. They were forced to see these films but most of them shut their eyes and all of them were very upset when the film ended. Cpl. J. said: "I suppose it was intended as propaganda, to make us want to fight the Japs, but I'd have run miles if I'd seen a Jap, after those films."

Their feelings of frustration in the camp were very great and they wanted to know why they could not have done something "useful." They felt it was a waste of money, giving them all new equipment which they would never use (they were all low Release Groups) and stated that some of the instructors knew considerably less than they did and that their knowledge was merely from books and not from experience. A sergeant, giving them gas instruction, said to them: "You'll want to know why you're doing this. So do I," but one of them added: "One of the best lectures we had there was on gas. The officer who gave it made it very interesting." An Indian and Austrian also gave them good lectures and the lecture on civil rehabilitation units was good but they had little patience with the officer who started his lecture by saying: "I've just come here today to fill in time." They also complained that they had to do a 5 mile run up hill, many of them before they had been medically examined.

They felt that many others should have to come to this hospital with them, but the Medical Officers were too busy and many men would not report sick. They felt as if they were treated like children at the camp and were allowed no say in anything. This was made more difficult because in their prison camps they had enjoyed considerable democratic freedom. They had their own committee of representatives and a private had as many rights as a Warrant Officer. Anyone who failed to come up to the required standard could be voted out. They had made their own rules and had seen that they were carried out for the good of the community. They discussed how in prison camps you had to develop thought and initiative, otherwise you starved. This kept them all mentally alert while they were constantly planning how to get the better of the Germans in order to get food, etc. Those who remained inert, lay on their beds, got a minimal amount of food and many of them were later removed to the Mental Hospital.

When they returned to duty in this country at the Selection and Training Battalion they were no longer allowed to think for themselves. This led to a discussion of some of the difficulties in this hospital and how they would like to alter things. Major Foulkes asked them what changes they would make. They were at first diffident in answering this but when they realized his question was serious, they attempted to do so. Cpl. J. suggested that we should get rid of the A.T.S. but the others did not agree with him. He adopted a somewhat rigid moral attitude that because of their proximity they placed temptation in the way of the men, but the others reminded him that he was a staid married man but this did not apply equally to all the other patients.

Cpl. J. then suggested that they should be allowed out until 10.30 p.m. so that they could feel they were men and not children, but that this was late enough for anyone and that it should be enforced very strictly and punishment for those who broke this rule should be made more severe. They described how in this hospital they considered that there were two factions—the psychiatric and the administrative. They felt that the psychiatrists had moved with the times but that the administrative side had not done so. Since we were now for all practical purposes a civil rehabilitation unit, some modification of the previous military hospital was required. They felt it should be run something like a rest camp and described a rest camp they had known in the Middle East where they stayed for 10 days, in which all ranks were abolished and everyone did his own fatigues. Anyone who saluted was threatened with immediate return to duty; the Officer–In-Charge and his second in command were called by their first names and a friendly democratic atmosphere prevailed. When they left the camp to return to duty they had no difficulty in recapturing a more military atmosphere. They stated: "When we left there the R.S.M. became an R.S.M. again but he was not one while he was there."

Commentary

These ex-prisoners-of-war were admitted together and readily formed a cohesive group. At first this was a well-defined entity which kept itself separated from the rest of the ward and the hospital and showed marked antagonism to other races and creeds in their conversation. As they improved, their social adjustment extended to an ever-widening field and the group gradually dispersed as they no longer needed the protection and support of the small group community.